Case Management Program for Frail Elders (CMPFE)
Authorization for Disclosure of General Client Information and Specific Health Information

Name: _____
Last First Middle Initial Previous Name

Birth Date: _____ Medicaid Number: _____

Home Phone: _____ Work Phone: _____

Address: _____
Street City State Zip

I hereby authorize _____ to share **PERSONAL**
(Case Manager Name and Agency Name)

INFORMATION AND HEALTH INFORMATION found in CMPFE authorized forms with the following:

Individuals and/or agencies listed in my Service Plan
The Iowa Department of Elder Affairs (DEA)
The Iowa Department of Human Services (Only if accessing Medicaid/Elderly Waiver services)

The information is to be released or shared <u>ONLY</u> for the purpose of service plan development, access to needed services from authorized providers and for DEA reporting purposes and quality assurance.

I authorize the area agency on aging (AAA) listed above to disclose relevant information in written or verbal form as well as by e-mail or fax. I understand that the use of e-mail or fax may result in the loss of confidentiality of medical records and I accept that risk. This authorization is for information already in existence and also for any information that may be generated while this authorization is in effect. I understand that I can cancel my authorization at any time by putting this request in writing and giving it to my CMPFE case manager. I understand that the cancellation will not apply to information that has already been released. Unless renewed or cancelled by me, this authorization shall expire on the date specified below. I understand I can refuse to sign this authorization but that my decision not to authorize the release of information may adversely affect my ability to fully secure some benefits and needed services. Authorizations are also given to the AAA listed above to share relevant information with individuals and/or agencies approved by me in this Release upon verbal approval by me.

I have read this form, or it has been read and explained to me and I understand its content.

Signature of the Consumer/Legal Representative

Date Signed: _____ Expiration Date: _____
(one year from date signed)

Relationship if not Consumer _____